



STATE OF TENNESSEE  
EMPLOYEE SICK LEAVE BANK  
SECOND FLOOR, JAMES K. POLK BUILDING  
505 DEADERICK STREET  
NASHVILLE, TENNESSEE 37243-0635  
TEL. (615) 741-5431 1-800-221-SEIL (7345)  
FAX (615) 532-3209

**FOR SLB USE ONLY**

Dept: \_\_\_\_\_  
Member: \_\_\_\_\_ Hrs. \_\_\_\_\_ Yr. \_\_\_\_\_  
Hrs. Used: \_\_\_\_\_ Reassess: \_\_\_\_\_  
Leave Expires: \_\_\_\_\_ Hrs: \_\_\_\_\_  
7.5 \_\_\_\_\_ 8.0 \_\_\_\_\_ S \_\_\_\_\_ D \_\_\_\_\_

**WITHDRAWAL REQUEST APPLICATION**

**Please complete and submit this Withdrawal Request Application through your Human Resources office. The Sick Leave Bank must receive this application no earlier than two weeks prior to the expiration of all accumulated sick, compensatory, and annual leave, but no later than thirty (30) workdays after the expiration of all accumulated leave.**

Employee's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_

Employee's ID Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred E-mail Address for Receiving SLB Determinations: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employee's Department and Position Title: \_\_\_\_\_

Have you previously received sick leave from the Sick Leave Bank? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Name used during previous withdrawal if different from present name: \_\_\_\_\_

1) My absence is due to \_\_\_\_\_

My first day absent due to this condition was \_\_\_\_\_

2) Did you enroll within the last 2 years? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide the names and telephone numbers of all the physicians from which you received treatment or advice for this illness/injury/medical condition: \_\_\_\_\_

3) Is your current illness/injury/medical condition work-related:

A. From state employment? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

B. From other employment or service connected? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate employer/branch of service:  
Employer/Branch of Service Name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

C. Have you filed a Worker's Compensation claim with the Division of Claims or another employer? Yes \_\_\_\_\_ No \_\_\_\_\_

4) Have you applied for Social Security disability? Yes \_\_\_\_\_ No \_\_\_\_\_ Date applied: \_\_\_\_\_

5) Are you currently approved for or receiving Social Security disability? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, effective date: \_\_\_\_\_

6) Have you applied for retirement through the Tennessee Consolidated Retirement System? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

7) Are you currently earning and/or receiving income from other employment? (excluding pensions) ..... Yes \_\_\_\_\_ No \_\_\_\_\_

**I provided my medical doctor/surgeon with a Medical Certification form to confirm my illness or injury as required by the Sick Leave Bank ("SLB") Guidelines. I instructed my medical doctor/surgeon to send the completed form directly to the SLB at the address listed at the top of the form. I understand that leave grants from the SLB shall not exceed more than thirty (30) consecutive days per application. I understand that the maximum number of days a member receives for an accident, illness, or an illness related to, resulting from, or recurring from a previously diagnosed illness is ninety (90) days. In addition, leave grants shall not exceed ninety (90) days within a twelve (12)-month period as defined in the guidelines.**

**I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any material misrepresentation of facts, I will not be considered for SLB benefits. The SLB Board of Trustees may remove me from the SLB, and I may be subject to disciplinary action up to and including dismissal. I hereby authorize the SLB to make all necessary investigations concerning this application. I further authorize and request any records or information, including but not limited to medical, Workers' Compensation, service connected disability, State Retirement or Social Security disability, that is sought in connection with this application be provided to the SLB.**

\_\_\_\_\_  
Signature of Employee or Legal Representative and Date

\_\_\_\_\_  
Signature of Human Resources Officer and Date

**Determination of initial applications made within ten (10) workdays from receipt of all necessary documentation.**